COVID-19
Virtual Press conference
8 March 2021

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TAG Dr Tedros Adhanom Ghebreyesus
RD Dr Roopa Dhatt
SG Professor Sarah Gilbert
OT Dr Ozlem Tureci
HE Helen
MR Dr Michael Ryan
SF Dr Soce Fall
MY Dr Michel Yao
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MK Dr Maria Van Kerkhove
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KOB Kate O'Brien
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GA Gabriela
DO Donato

00:00:07
CL Hello and good day to wherever you are joining us today on this very special day, Monday 8th March 2021 and International Women's Day. Happy International Women's Day to all fantastic women out there and of course here in the room.
My name is Christian Lindmeier and I welcome you to today's global COVID-19 press conference. Simultaneous translation is provided in the six official UN languages, Arabic, Chinese, French, English, Spanish and Russian, plus Portuguese and Hindi. As special guests on this important day we have online Professor Sarah Gilbert from the Jenner Institute and Nuffield Department of Clinical Medicine at the University of Oxford, co-founder of Vaccitech and developer of the Oxford AstraZeneca vaccine against COVID-19.

Professor Ozlem Tureci, co-founder and Chief Medical Officer of BioNTech and the developer of the Pfizer BioNTech COVID-19 vaccine. Dr Roopa Dhatt, Executive Director of Women in Global Health. Now let me introduce to you the other participants. Present in the room here are Dr Tedros Adhanom Ghebreyesus, WHO Director-General, Dr Mike Ryan, Executive Director of the WHO Health Emergencies Programme, Dr Maria Van Kerkhove, Technical Lead on COVID-19, Dr Mariangela Simao, Assistant Director-General for Access to Medicines and Health Products, Dr Soumya Swaminathan, Chief Scientist, Dr Kate O’Brien, Director for Immunisation, Vaccines and Biologicals, Dr Sylvie Briand, Director for Global Infectious Hazard Preparedness, and last but not least, Dr Annamaria Henao-Restrepo, Co-Lead for the R&D blueprint at WHO.

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Online we have further colleagues who will be ready to answer questions if required; Dr Soce Fall, Assistant Director-General of Emergency Response, Dr Michel Yao, Director of Strategic Health Operations, and Dr Peter Ben Embarek, WHO Expert on Food Safety and Zoonosis and the International Lead of the WHO-convened global study of the origins of SARS-CoV-2.

Now without further ado I'm handing over to the Director-General for his remarks.

TAG Thank you. Thank you, Christian. Good morning, good afternoon and good evening. On 30th January last year I declared a global health emergency over the spread of the novel coronavirus. At the time outside China there were fewer than 100 cases of COVID-19 and no deaths.

I wish to be very clear; a Public Health Emergency of International Concern is the highest level of alarm under international law. Over the next days and weeks we continued to sound that alarm loud and clear and we continued giving countries the strategies, the guidance and the tools they needed
to prepare for, prevent, detect and respond to the spread of this new virus.

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On 5\textsuperscript{th} February we started our daily press conferences, informing the world about the risks this new virus posed and the steps that governments and individuals needed to take to stay safe. We continued to warn that the world had a narrow window of opportunity to prepare for and prevent a potential pandemic.

One of the things we still need to understand is why some countries acted on those warnings while others were slower to react. In the following weeks the number of affected countries and the number of cases globally grew rapidly, which led us to describe COVID-19 as a pandemic on 11\textsuperscript{th} March last year.

But we must be clear that that was not the moment at which we sounded the highest level of alert. That moment was on 30\textsuperscript{th} January.

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Right now WHO's focus is on supporting all countries to end the pandemic, including with vaccines and the public health measures that have been the bedrock of the response for 15 months.

We have come so far, we have suffered so much and we have lost so many. We cannot, we must not squander the progress we have made. We have the tools to control the pandemic but we can only do it if we use them consistently and equitably.

Science, solutions and solidarity remain our guide. There are no short-cuts. As you know, today is International Women's Day. In many ways women have suffered disproportionately from the pandemic. We have seen appalling increases in violence against women and reduced access to services for sexual and reproductive health.

In relative terms employment losses have been higher for women than for men. Women have also borne an additional and disproportionate burden of care for children and older people but women have also been at the forefront of the response.

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About 70\% of all health workers globally are women and they have played a key role in delivering care and saving lives. But although they make up the majority of the global health workforce women only hold 25\% of leadership roles in health.
That's why in February WHO launched the Gender-Equal Health and Care Workforce initiative to increase the proportion of women in leadership in health and care, to promote equal pay, to protect women in health and care from sexual harassment and violence at work and to ensure safe and equal conditions for health and care workers including access to personal protective equipment and vaccines against COVID-19.

To talk more about the initiative today I'm delighted to welcome Dr Roopa Dhatt, the Executive Director of Women in Global Health. Roopa, welcoming and thanking you for joining us today and you have the floor.

RD Thank you, Dr Tedros. Let me start by wishing you a very happy International Women's Day. It really is a pleasure to be here with you, Dr Tedros, and the rest of the esteemed WHO colleagues, especially the women in the room. I also want to acknowledge the other distinguished women, especially Professor Sarah Gilbert and Dr Ozlem Tureci, both very distinguished women, on this theme of International Women's Day which is women in leadership.

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Just over five years ago I was one of the four early career-women in medicine who met on Twitter asking the same question; why are there so many incredible and well-qualified women in global health but so few in senior decision-making roles?

That was how Women in Global Health was born and in the last five years we have been joined by women from all around the world asking the same question and committed to change. Today as Executive Director of Women in Global Health I lead a growing global movement that has been largely driven by volunteer womanpower, has 50,000 supporters with 24 national chapters.

The COVID-19 pandemic has exposed the fundamental flaws and inequalities that we must put right urgently if we are to be better prepared for the next pandemic. The question we were asking about global health leadership five years ago is just as relevant today.

Women are around 70% of the health and care workers but hold only 25% of decision-making roles, as Dr Tedros has already mentioned and this pattern has been repeated in this pandemic.

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Our research shows that 85% of national COVID-19 taskforces have majority male membership. The extraordinary work done by
women in the health and care workforce in this pandemic has not earned them an equal seat at the decision-making table and as a result we have all lost out on their talent and expertise.

I was asked to speak about my year and it's been a rollercoaster, as it has been for so many women. This year I've tried to balance leading a fast-expanding Women in Global Health movement with doing hospital shifts as a US physician with COVID patients.

My husband is also a doctor, treating the most vulnerable cancer patients so for the sake of his patients and mine when not in hospital we have largely been shielding at home and again, like women all over the world, I've done two jobs and managed by losing sleep, juggling and leaning on some brilliant women around me.

In the middle of such a devastating global health emergency I've been proud to make a contribution by doing the job I was trained for but like many health workers I've also felt furious that well-resourced countries were not ready for this pandemic even though it was not unexpected.

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I have also felt angry that my sickest patients were often disproportionately black or Latinas and this is not new. COVID-19 does not discriminate but societies do. COVID-19 has exposed long-standing inequalities within and between societies and they threaten to leave inequality wider than before, including between women and men.

At the same time as being proud to work as a physician I've been proud to build the Women in Global Health platform and enable women from low and middle-income countries to be heard at the global level.

In this pandemic as a health worker I know I'm the lucky one. I have had the protection of physical protective equipment, PPE, when many of my colleagues in low-income countries have had to work on the pandemic with little or no protection.

I've been paid for my work when I know a large number of women community health workers have worked unpaid and underpaid, going door-to-door to identify COVID-19 cases.

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I've felt safe in my clinical setting when women health workers in other countries have been attacked and stigmatised for doing
their jobs. I've also been vaccinated when vaccines have only recently started to reach Africa and it may be years before they reach some of my Women in Global Health colleagues around the world.

From my vantage point both at the interface with patients and surveying the global landscape with Women in Global Health I want to conclude with four points. First, in this pandemic and in normal times women are the social shock-absorbers in a crisis in families, communities and societies.

It is the women in this pandemic who have borne the increased burden of unpaid work at home and as schools were closed and it is girls in the poorest families who have been taken out of school and forced into earlier marriages when families needed one fewer mouth to feed. The lost hopes and dreams of those girls can never be recovered.

Second, when women are marginalised in leadership decisions are made that ignore the realities of women's lives and cause lasting harms and death. I believe that women would have not made the decision to treat reproductive and maternal services as non-essential.

Women know that pregnancy does not stop for pandemics. One-third of countries in a WHO study reported disruptions to maternity services in the pandemic. Women have died, just as they died in Ebola outbreaks for the same reason.

I believe women as the majority of the health and care workers would have designed PPE to fit women and their bodily functions. It is simply an insult that PPE is designed for men and the poor fit leaves women more exposed to infection.

We have a chance to be equitable and we must accelerate vaccine equity now for all health workers, especially for women who comprise 70% of the health and care workforce.

I don't believe women in leadership would have imposed lockdown policies without considering protection of the many women and children locked down with abusive men. Gender-based violence has increased significantly everywhere because home is not a safe place for many women. Again women have died because decision-makers got this wrong.
Third, there has been considerable debate on whether the performance of female political leaders in this pandemic has been better than their male counterparts. Some have noted that the more inclusive communication skills of female leaders have helped build collective action, public trust and compliance.

I would argue that in general women leaders have been decisive, focused on the evidence and communicated more honestly with their citizens. I would contrast that with the war analogies and denials heard from many men in power. Since only 6% of countries are primarily led by women we should test this by electing equal numbers of male and female leaders and measuring the impact.

Finally my fourth point is that we cannot base something as critical as global security on the unpaid and underpaid work of women. Women in the health and care sector are clustered into lower-status, lower-paid jobs, frequently subject to violence and harassment.

The gender pay gap in the health sector is 28% and in reality it is much higher because half of the US$3 trillion women annually contribute to health is in the form of unpaid work. The poorest women in the world currently subsidise health systems with their unpaid work.

That has been exposed loud and clear by this pandemic and it is not new. This pandemic has to break with the past. This has to be the year we commit to a new social contract for women in the health and care sector. This is why we have launched this initiative in partnership with the World Health Organization and the Government of France.

Women in the health and social sector want the means; decent work, safety, dignity, fair pay and equal leadership to do their jobs better and deliver stronger health outcomes for everyone. Equality of women and men in the health and care leadership will strengthen health security and health systems for all of us. Thank you.

TAG  Thank you. Thank you so much, Roopa, and we look forward to our continued partnership to ensure women everywhere get the opportunities, the recognition and the safe and dignified working conditions they deserve. I hope the MOU we signed with your organisation will enhance that.
Around the world women scientists are leading research and response in many areas of health. A new Women in Science compendium compiled by the special programme for research and training in tropical diseases, which is based at WHO, celebrates 15 women scientists working in Africa, Latin America and Asia.

Today I'm delighted to be joined by two women who created two of the COVID-19 vaccines now being rolled out globally; Professor Sarah Gilbert from the University of Oxford, who developed the Oxford AstraZeneca vaccine, and Dr Ozlem Tureci, who is the co-founder and Chief Medical Officer of BioNTech and developer of the BioNTech Pfizer vaccine.

Professor Gilbert and Dr Tureci, it's an honour to have both of you with us today and congratulations to both of you for your pioneering work and on behalf of the whole world thank you for the vaccines that are now bringing hope to so many people. Professor Gilbert, you have the floor.

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SG Thank you. On International Women's Day I would like to start by acknowledging the enormous contribution made by women to get us through this pandemic. Many women have volunteered to help out in their communities and in vaccination centres.

Of the vaccine team in Oxford two-thirds are female and all have worked incredibly hard for over a year, often while dealing with family responsibilities. However, of the senior positions in the team only one-third are women. Women continue to be under-represented on the boards of companies as well.

There is more to do when even in a field where women are very well-represented at junior levels they do not progress to the top of the profession and of course in many other disciplines and in countries across the world women face barriers at all levels.

There are concerns that the pandemic could have more effect on the careers and livelihoods of women than of men and as we begin to make our plans for recovery we must not neglect this. Within Oxford University I'm seeking to understand the barriers to promotion of women. This is something that should be widened in order to find the barriers wherever they occur and break them down.

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I work on the development of vaccines against viruses that can cause outbreaks and potentially pandemics using a platform technology that could be adapted to produce many different vaccines very quickly.

The technology itself is well understood and was approved by the WHO R&D blueprint exercise several years ago. Using the same technology allows us to understand many aspects of vaccine development before we have identified the virus that we want to vaccinate against.

We already know how to manufacture and test the vaccine, what dose to use, the expected side-effects and the overall safety, enabling us to move very quickly when a new virus is identified. Our technology uses a modified adenovirus to produce the vaccine but there are other approaches that can be used.

I worked on the development of vaccines against influenza, Ebola and MERS before COVID-19. Following Oxford's partnership with AstraZeneca and the collection of data from clinical trials the vaccine is now in use in many countries and we are seeing how effective it is in use, protecting 80% of hospitalisations in those aged over 80 years even after one dose and reducing disease in the over-70s by 70%.

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We have more work to do on assessing the ability of the vaccine to work against different variants and whether an update to the vaccine is needed but we are making preparations to do that if necessary. We are continuing to monitor immune responses in those vaccinated so that we can assess when a booster might be needed.

As vaccinations are rolled out around the world with the most vulnerable being protected first we need to continue to monitor virus transmission and apply all available measures to reduce it to protect those not yet vaccinated and reduce the chances of new variants arising.

To increase the amount of vaccine doses that can be delivered across the world I encourage vaccine manufacturers to form new partnerships in diverse geographical locations to manufacture, fill and distribute vaccines that are already approved.

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We need to work together and use all available resources to do this. Thank you.
Thank you. Thank you so much, Professor Gilbert. Dr Tureci, over to you.

Thank you so much, Director-General, and thank you also for this opportunity to join my sisters not in crime but in crisis in this discussion. It's a pleasure times two, firstly because it is by the WHO DG; second because it's on International Women's Day. Both stand for causes which are very close to my heart.

I'm a wanderer between three worlds. As a trained physician I grew up in patient care. As an immunologist I'm deeply rooted in academic science and as an entrepreneur who has founded companies I'm immersed in the biopharm industry and in the private sector.

In all of these three worlds the lack of gender equality is obvious every day. The higher the ranks the more disproportionate the representation of women; the higher the ranks the more value-destroying the lost opportunity of mobilising precious talent.

We are in the midst of a global health crisis now, a crisis of a scale and pace that is unprecedented in modern times and sadly, as already noted by the Director-General and by Roopa, the pandemic has exacerbated the challenges women habitually face.

In times of crisis, as in times of war, there is a side-effect, namely the side-effect that all hands are needed on deck, which means inclusion out of desperation, calling to action those who otherwise are excluded.

In this current crisis women have followed the call, as they always do and stepped up. As a consequence we see women at the forefront in the fight against COVID-19, as leaders and also as comrades. Three of those women - Roopa, Sarah and myself - have the honour and the pleasure to be here today, not because we are the exceptions but because we represent the many women who have assumed outsized roles, responding to COVID-19 including as front-line healthcare workers, as mobilisers in their communities, as vaccine developers, policymakers and caregivers at home.

At BioNTech we are fortunate. We have 60 nations under our roof and women make up 54% of our total workforce. At 45% women account for almost half of our top management and we like to think that being a gender-balanced team has been critical for
making the seemingly impossible possible; to develop a COVID-19 vaccine within 11 months without short-cuts.

I personally feel prepared to continue the marathon to conquer this global health crisis with the women in my company and the passionate and hard-working women worldwide being part of a COVID-19 response. This is why I very much want to see women enabled today and also tomorrow.

Speaking of COVID-19 response let me for a moment share with you some personal thoughts about the pandemic in a broader context. The grand mission is to achieve herd immunity and until we have achieved it to follow SARS-CoV-2 transmission protective measures.

The last 14 months have brought us closer to this aim. Several vaccines are authorised, approved, are being rolled out. We at BioNTech Pfizer are proud to be part of the solution and the more our peers are successful with their vaccine developments the better for the world.

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There are those unknowns about which people are concerned and I would like to briefly touch upon them. One is the duration of protection. The answer to this question requires the passage of time and the diligent accumulation of data. Whatever the data shows, as long as we have vaccine technologies and further development that allows for boosting this can be addressed.

Another question people are worried about is virus variants. Viruses that replicate do accumulate mutations. This is inevitable. With suppressed replication there will be fewer mutations, which means that the best way to protect us from super variants of viruses is immunity.

Not all virus variants are and will be of concern and against many variants just boosting with our original vaccine will suffice. What however is important is to be prepared; being prepared technology-wise, which means to have a versatile platform which allows for rapid response to a variant of concern; being prepared process-wise which means to have the blueprint for execution ready on the shelf.

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And being prepared to make informed decisions which means to have a clear, scientifically sound definition when the variant is of concern and should trigger an aligned vaccine adaptation.
Now that vaccines of high efficacy backed by data are available and more of them will be soon the most important next milestone for all of us is global equitable roll-out. Mission herd immunity means no-one will be safe until everyone is safe across genders, ethnicities, economies and nations.

This requires building, expanding, up-scaling production capacities, improving supply chain conditions, securing funding, adapting to the world's regional transportation and health infrastructures and policies and much more.

It importantly also means dealing with complex geopolitical, global ethics and societal frameworks, frameworks which already pre-pandemic reflected inequalities. With this the true grand challenge is to ensure collective action and global solidarity first and foremost.

Let me end with wishing all of you a happy Women's Day. May the celebration of the next one be under conditions of normality, a better normality that is gender-inclusive. This is up to us to achieve. Thank you.

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TAG Thank you. Thank you so much. Teşekkür ederim, Dr Tureci, and thank you once again to you and Professor Gilbert for the incredible contribution you have made.

Finally to mark International Women's Day WHO is today launching a new global breast cancer initiative to reduce mortality from breast cancer by 2.5% every year until 2040, saving 2.5 million lives.

Breast cancer has now overtaken lung cancer as the world's most diagnosed cancer. Survival five years after diagnosis now exceeds 80% in most high-income countries but survival rates are much lower in lower-income countries. There is much we can do to save these women's lives.

Finally, as you know, our work at WHO would not be possible without our own incredible women, including those you see here today, who have joined us today here in the room; Annamaria, Kate, Maria, Mariangela, Soumya and Sylvie - three Marias actually - and thousands of others you don't see all over the world.

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To all of our women colleagues I want to say thank you for everything you do every day to promote health, keep the world safe and serve the vulnerable. Christian, back to you.

CL Thank you so much. With this we'll start the round of questions and answers. Before we get there let me remind you to raise your hand and then unmute yourself when it's your turn and please one question only. We'll start with Helen Branswell from Stat News. Helen, over to you.

HE Thank you very much, Christian. I'm looking for an update on the Ebola situations in DRC and Guinea, please. Also is there a shortage of the Merck Ebola vaccine? I think I read that there were problems with supply in Guinea. Can somebody please clarify?

CL We'll start with the Ebola question possibly. Are we ready? Okay, Dr Ryan, please. We'll start with the second question.

MR Hi, Helen. I think Soce or Michel will give you the update but my understanding is we don't currently have an issue with vaccine supply. To my knowledge we have nearly 33,000 doses of vaccine in country. I'll pass to Soce and to Michel to give you an update.

SF Thank you, Mike. Just to confirm that we don't have any supply issue in Guinea. As you rightly said, we have right now 33,000 doses and we are using ring vaccination, meaning that we are vaccinating the contacts of cases, contacts of contacts and probably contacts.

At global level we have more than 500,000 doses for the Merck vaccine so we don't have an issue for vaccination. But it is important to continue [inaudible] at global level because we have seen while the global community come together how we can be strong and provide more tools for public health in general.

So in terms of an update, compared to last Friday we don't have any change in terms of number of cases. We still have 11 cases in Congo but in four health zones, meaning four districts in the same area.

Now for Guinea we still have 18 cases, as we reported last week, including four probable cases. What is important is we need to
continue for example in Guinea improving some of the key performance indicators like the number of [unclear] coming from the community including the number of dead [unclear] because we want to make sure that we can test the maximum of [unclear] coming from the community in terms of death and of probable cases.

This is extremely important and on the development - and Annamaria is sitting there - we have been co-ordinating with neighbouring countries for them to be able to start vaccinating healthcare workers next week. I think this is an important development. Thank you.

CL Thank you. That was Dr Soce Fall, Assistant Director-General, Emergency Response. Now Dr Michel Yao, Director, Strategic Health Operations.

MY Thank you very much. In fact in this response, both in DRC as well as Guinea, our role is really to bring all this innovation and ensure that at least the baseline that is here now due to past Ebola outbreaks and also of local experience, is to ensure that all these innovations are fully implemented.

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So we just travelled from the field and the key contribution is the WHO aspect, working hand-in-hand with national authorities to improve quality. But as Soce mentioned the early warning, we are now ensuring that in Guinea we decentralise the response into districts so that all the neighbouring districts enter a response mode to increase surveillance and detect promptly.

We are also trying to strengthen the treatment capacity. Some of the baseline is there but we are working closely with our NGO partners to increase this capacity as well as also increasing laboratory capacity.

We have some collaborative centres, one from Germany which we just learned will support the laboratory capacity. So for the time being the situation is more or less stable but we should ensure that we remain vigilant to improve the quality of the response.

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CL Thank you very much. With this we go to the next question and that would be Simon Ateba from Today News Africa. Simon, over to you. Please unmute yourself. Simon, do we still have you?
Yes. Thank you for taking my question. This is Simon Ateba for Today News Africa in Washington DC. I would like to know if the WHO is still using the WHO COVID-19 app to help vaccine acceptance, fight fake news and share the right information especially in Africa, the same way it did for testing and other public measures at the beginning of the crisis. Do you still have that partnership with Google, Google News, Facebook, Twitter, Instagram and other IT companies and has Facebook donated more money to the WHO? They just made more billions as more people work from home. Thank you.

Thank you, Simon. We'll start with Dr Van Kerkhove.

Yes, I can start but I think others should supplement this because there're a number of ways in which WHO has been working to get good information, high-quality information out about the virus, SARS-CoV-2 virus, the disease, COVID-19 that infection causes and to fight against misinformation and disinformation.

We actually have Dr Sylvie Briand here, who has been leading the fight against the infodemic and I will ask her to supplement this but we are continuing to work with the major developers, Google and Facebook and all of the different companies, to help support highlighting high-quality information and make sure that there's fact-checking ongoing and make sure that those who search information have that high-quality information up-front. So that is a relationship that continues and we have many people who are in the room and in our communications department who are working with that relationship day in, day out to make sure that we find innovative ways to get good information out to everyone who needs it. Sylvie.

Absolutely. In addition I have to say that in Africa we've created a collaborated effort called ERA, which is the African infodemic response alliance. This is work with various partners including UNICEF, IFRC and a few other partners who assist us with circulating appropriate information.

Appropriate information circulates on social networks and various platforms and also in the physical world, not just in the virtual world. So we're trying to have an approach that is both overall and holistic. We're trying to reach people and provide them with the right information at the right time.
This might be videos, this might be through webinar presentations, discussions with communities so we have several media to get the message across. Indeed the WHO has always had a close relationship with Google, Facebook and other social networking platforms and they're working hand-in-hand to ensure that the right information is getting out as fast as possible and at least as fast as the bad information because we have seen that unfortunately inappropriate information, poorly interpreted information circulates just as quick if not quicker than the right information.

So access to the information is good. As much as we're doing to accelerate vaccine availability we're trying to make the information available as well.

CL    Dr Ryan.

MR    Just to add because I think it's important just to say that WHO's collaborating with all sorts of companies and we're dealing with private and public sector, academic sector, we're dealing with start-ups, we're dealing with major global players when it comes to managing how we get information out to people, how we deal with the infodemic, how we deal with developing new digital tools.

We're currently working on digital vaccination certificate, AI-driven epidemic intelligence, AI-driven social listening tools and many other things. WHO's role is not to develop these things. Our job is to be in a sense the convenor, to bring together policymakers from around the world, to decide where the gaps are and then find the institutions both public and private who can help us to fill those gaps with an equality approach to doing that so we can transfer technologies and transfer and absorb some of the wonderful new technologies that are developing, be it in vaccines or drugs or diagnostics or information technology.

So I think WHO sees information technology and our ability to use it effectively and our ability to manage and use information effectively as being a massive weapon against pandemic diseases but also as a huge platform to deliver primary healthcare, to deliver universal healthcare.

MR    So I think WHO has really emerged during this pandemic and under Dr Tedros' leadership is really trying to leverage and exploit the digital revolution for health and for health equality.
Thank you very much. With this we move to the next; Robin Millar from AFP. Robin, please unmute yourself.

Thank you. Dr Tedros, as you said, it's now coming up to one year since you first used the term pandemic to describe the situation although the highest level of alarm available to WHO had been declared already in January and as you said, some countries were slow to react to that.

On reflection a year on do you think if you'd used the term pandemic sooner it would have made any difference to how those countries reacted? Thank you.

I will begin. As Dr Tedros has said, the responsibility of the organisation is to raise the alarm, to set progress in motion. From January 1st 2020 WHO had instigated its emergency management team in which we activated our systems at the three levels of the organisation to take action against the cluster of pneumonia of unknown aetiology that had been reported from Wuhan.

Since then we have been setting guidance and advice to our member states, to everyone everywhere about actions that needed to be taken. We issued - the Director-General announced a Public Health Emergency of International Concern, a global health emergency, the highest level that we can under international law, on 30th January. That was our highest level of alarm.

We had used the word pandemic or the potential for this to become a pandemic earlier than March 11th because we were setting things in motion to prevent that from happening and many countries did that. Many countries who had had some experience with infectious diseases before so some trauma of some big outbreaks before... to really activate their systems and initiate their systems right away.

They knew from previous experience that this required an all-of-government, all-of-society approach and really to act quickly and act robustly with the systems that they had in place. Many countries did that and you can see over and over again the countries that were able to initiate plans to rapidly identify the earliest cases that were to arrive and to do cluster investigations so that they prevented any initial cases from becoming clusters and clusters becoming community transmission.
They really did a lot in terms of activating their community workforce and used the testing capacities that they had strategically. They fared better in the sense that they were able to prevent the worst from happening, the worst from taking hold.

From our point of view - and I'm sure Dr Tedros and Mike may want to come in here - we were doing our best to inform every day on the situation at hand, informing the world on what was known about this virus, the dangers of this virus and saying from the start that this was a dangerous virus and that systems needed to be activated.

So we didn't just say that; we followed that up with action, we followed that up with a full strategic preparedness and response plan that was published four days after the alarm, this Public Health Emergency of International Concern was announced.

We worked with governments, we worked with countries, we worked with communities to make sure that those plans could be actioned and tailored in the appropriate way for countries around the world.

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We continue to do that. We've just issued an update to the SDRP, the strategic preparedness and response plan 2021 where we have added vaccines and vaccination into the global strategy. Our focus remains on ending the acute phase of this pandemic, making sure that we get societies up and running, we prevent as many infections as we can and we save as many lives as we can.

We can only do that by acting together so we will continue to do that until this pandemic is over.

CL Dr Ryan.

MR Yes, maybe I could be a little bit more direct because I think the journalist is asking us, if we had yelled then more people might have heard us. I think many people did hear, many countries did hear and took action and it's very instructive because I think perception of risk is very much about the perspective you have, about how much risk you're at.

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Unfortunately if you're in a valley and a dam bursts you know you're at risk and you take action. If you're standing on the mountaintop you don't feel the same level of risk until the waters rise and I fear too many countries thought they were standing on a mountaintop watching the waters rise to consume and
overwhelm others and what everyone didn't realise as the waters rose to consume them.

Again I'll remind you that the International Health Regulations is not WHO's. It is a solemn legal agreement between 194 member states agreed in 2005 where 194 countries came together and agreed with each other what would represent the highest level of alert for global public health emergencies.

That came into force in 2007 so the fact that countries... I can fully understand maybe from a media perspective that a member of the public and others might not react to the declaration of a global public health emergency under the IHR by the Director-General.

But that is an agreement between all member states on this planet who agreed in law that this would represent the trigger to collective action in response for containment.

00:47:27

So I think we have to ask ourselves, yes, maybe we need to shout louder but maybe some people need hearing aids.

CL  Thank you very much for this. Before I get to the next question from Tomo Naguchi, Kyodo News, let me just remind everybody that we still have our three special guests today online and if you want to raise a question with them now is the chance. But first Tomo Naguchi, Kyodo News, please unmute yourself.

TO  Hi, Christian. Can you hear me?

CL  Yes. Please unmute yourself. Please go ahead.

TO  We are heading towards the end of winter in the northern hemisphere. Could you provide us with the latest figures and trends of seasonal influenza this year? I assume we are seeing a decrease in cases and deaths but have the measures taken to counter COVID-19 contributed to this and if that's the case can we say that we've found effective measures to counter seasonal influenza, which was thought to be uncontrollable in the past? Thank you.

00:48:43

CL  Let me hand over to Dr Sylvie Briand, please.

TR  Thank you very much for the question. Yes, indeed we are following up on the influenza virus that's circulating throughout the world and some months ago already in the summer
hemisphere we saw that there were very, very low rates of circulation of influenza and in the north we're seeing that there's very little circulation.

There are various hypotheses on this. The most satisfactory is that the measures that are in place for the reduction of the transmission of COVID are also very effective for flu. We saw that in 2009 with the H1N1 pandemic and so we see flu infections reducing but other seasonal viruses such as gastroenteritis also have seen reductions this year.

So I think it's very important to understand that these public health measures have a very significant impact for population health and it's important to continue applying them to reduce the transmission of COVID but also that of other illnesses.

The fact that we are living in a world where we are in permanent contact with viruses; we have to look at how the situation develops and if we're going to stay in the same situation over time or when we've vaccinated the majority of people against COVID-19 we'll see what dynamics there will be between the various viruses.

But for now the public health measures have been extremely effective. Thank you.

Thank you very much. Let's move on to Corinne Gretla from Bloomberg. Corinne, please unmute yourself.

Hi. Thank you for taking my question. I wanted to ask about Myanmar's vaccine roll-out, which is being derailed by the coup there. They've stopped updating vaccination numbers and while the generals say the roll-out is continuing a third of hospitals are estimated to be closed as medical workers join the strikes and protests.

I just wanted to ask, how concerned are you about reports of disruptions to vaccine distribution in Myanmar, and maybe what your country reps are observing and what they're reporting back. Thank you.

Thank you, Corinne. We'll hand to Dr Ryan first. No, sorry. Dr O'Brien.

Thank you for that. I think the first thing to emphasise is what the Director-General has said over and over again; that the response to the pandemic needs to be a public health response
and we need to take out of that response any politics. Clearly for any setting that is in conflict, a vulnerable setting, a fragile setting the risk to the population of the cessation of services or the slow-down of services or danger in getting services is of enormous concern for the control of the pandemic, especially as we're in the early phases of vaccine roll-out.

The access of people to those vaccines is incredibly important. Vaccines do have a shelf-life to them and it means that if vaccines are not being delivered on time and as planned this precious resource that is now being deployed across countries that previously had not had access to vaccines is something that is going to waste.

So the concern for people in all countries who are in conflict settings is of high concern for us and we will continue to monitor this and call for the continuation of services for people, not only vaccination for COVID vaccines but also the other life-saving essential services including vaccination against other deadly diseases for which we do have vaccines. Thank you. Perhaps there are others; Mike, maybe you want to comment.

00:53:14

MR   Thanks Kate. No, spot-on. I think Kate raises a much broader issue that's not just about the commodities like vaccines. It's about the health infrastructure; it's about the health workers. The health system is a complex thing. It requires the efficient delivery of primary healthcare services at the lowest possible level in the system.

That requires trained workers working in safety with the proper training, with the right tools, be it a vaccine or be it a drug, be it something to treat malaria, something to treat TB or a vaccine to prevent a childhood illness or even COVID.

Those healthcare facilities are very precious and those healthcare workers are very precious and what we're seeing again and again and again is in situations of conflict populations losing access to healthcare because of the direct interference and the delivery of the healthcare, be it in terms of the delivery of the commodities, the protection of those health workers or the protection of those healthcare facilities.

00:54:16

I won't comment specifically on the situation in Myanmar but anything that interrupts the delivery of health services needs to be addressed very, very, very quickly and that's not just in
Myanmar. We've seen the same issues in Yemen; we've seen the same issues in Syria; we've seen the same issues in Libya; we've seen the same issues in Tigray.

The fact remains that for many areas we've having very great difficulty getting information on COVID-19 and other important health issues. Populations have less and less access to health services. We can't even assess at the moment availability of health services in the Tigray region of Ethiopia because we don't have access to even assess those facilities.

So I think this is raising a much bigger issue and that is, are we going to continue to allow health services to be undermined, interrupted and often attacked in the middle of our political or military conflict where the only people that suffer are civilians?

00:55:22

That's the bottom line and we're seeing increasingly health workers being implicated, intimidated, attacked and not being able to access their place of work and citizens not being able to access care. This is not only an issue for EMR. This is an issue right across the spectrum and we also need to show some balance in being able to look at all of these different crises and not treat one crisis differently to another.

CL    Thank you very much. With this I think we come to possibly the last question and we'll go to China Daily. This would be Chen Wihua. Chen, over to you. Please unmute yourself.

CH    Thank you very much. My question is regarding... I'm based in Brussels. The EU has been talking about this vaccine certificate for a while and China also over the weekend proposed a so-called international travel health certificate; similar things.

Could you share WHO's thinking on this, how, when this is possible, how feasible that is, what would be the challenges for such an idea? Thank you.

00:56:40

MR    Maybe I can start on the policy issue. There is an issue here on how we would certify vaccination. That's very different to how certification of vaccination would be used to either facilitate or prohibit certain activities in society.

WHO's clear and the emergency committee of WHO have been clear; at the present time the use of certification of vaccination as a requirement for travel is not advised because quite simply
vaccination is just not available enough around the world and is not available certainly on an equitable basis.

The measurement of vaccination status is a very important part of normal public health service delivery and maybe Kate and Soumya will speak to how a digital certification of vaccination starting with COVID could be a real addition to our public health architecture down the line.

But if we could separate the digitalisation of certification, which I think is a very positive development - and we have a team working in-house on that and again Kate and Soumya may update on that - from what is the issue regarding policies around vaccination and what you're allowed to do when you're vaccinated or when you're not vaccinated.

00:57:57

That will have implications for national policy and for international travel and the right to travel down the line but I think there are real practical and ethical considerations as well that countries will have to address because if access to vaccine is inequitous then inequity and unfairness can be further branded into the system if we continue to make decisions on what people can and can't do, where they can and can't go on the basis of being vaccinated when being vaccinated itself is not something that everyone has equal access to.

There are also people who for whatever reason cannot be vaccinated or do not wish to be vaccinated so this is a very important societal discussion and I think we need to be very careful and Kate may speak to that as well.

CL Dr O'Brien, please.

KOB Just a couple of things to add to what Mike had to say. We're incredibly supportive of electronic vaccination certificates for a number of reasons, not the least of which are the efficiencies of time, the accuracy of the information, the link to the products that have been received.

It facilitates assessment programmes on safety of products. It allows parents or individuals who have been vaccinated a greater autonomy on those records for their own use. The completeness of vaccination is facilitated through electronic individually-held records because you can easily identify what else the person has received or not received in terms of the vaccines that they need and those can be served at the same time in many cases as any given vaccine.
So there's a real range of positive benefits from an electronic vaccination certificate that an individual or a parent of a child is able to hold and that's really distinct from what it's used for. The standards for having electronic records and individually-held records are some of the most important things to ensure that there's privacy around those records, that they are credible records that have safety around the record itself, that they're documented in a way where the information can be shared across service platforms so if you go to one clinic there has to be a way for it to be read and verified and identified at another clinic.

01:00:30

So what we're doing is establishing the standards for those kinds of records and establishing the basis, the technical basis on which any given app or platform would have to meet a technical basis to assure that all of those elements are in place.

As Mike said, this is a really distinct issue from what you actually use those records for to potentially constrain people from their opportunity for travel as a result of COVID and COVID vaccination so I won't repeat what Mike said but we really want to make the distinction between the benefit that we see for individual electronic vaccination records for a programme of vaccination and individual use and then this distinct issue around using it for the purpose of a requirement on travel.

CL Thank you very much, all. I hear and we see we have time for possibly two more questions. Let me start with Gabriela Sotomayor, Proceso, Mexico. Gabriela, please unmute yourself.

TR Good afternoon.

GA Question. I thought I was without hope but thank you very much. I want to congratulate the women at WHO and the guests as well. My question is on Mexico. The situation is still bad and it is one of those countries that underestimated the emergency and continues to pay for it.

01:02:08

Almost 200,000 deaths are reported but it is estimated to be double. Transmission is still very active and deaths; health personnel, most women, have not yet been fully vaccinated. Violence against women; we don't have anything to celebrate; there are ten femicides every day in the country.

What is the forecast, what is your assessment? Also do you have up-to-date information on the variants in the country? Thank you.
Let's start with Dr Van Kerkhove.

Hi. Thanks for the question. Indeed circulation is still quite high in Mexico but the trends are reducing; I know at a national level we can say that and it varies by the locality within a country and that's true in all countries.

But seeing trends go down is a good sign. It doesn't mean that there's not more to do and as you know, Gabriela, it's all about this comprehensive approach that countries are applying. It is never, never too late to turn it around and many countries have done that.

Mexico is showing us that they can reduce transmission with a comprehensive approach so making sure that testing is strong and you have a good testing policy that's linked to public health action, making sure that cases are cared for. We do see reductions also in mortality in Mexico and also globally for the sixth consecutive week we've seen a decline in deaths across the world and that is largely due to stronger clinical care, patients entering the clinical care pathway earlier and receiving the care that they need.

Again here we still have a long way to go but I think it's really about making sure we stay the course and making sure that even though we have vaccines and vaccinations coming online we still adhere to the individual-level measures; the physical distancing, the mask-wearing, hand hygiene, respiratory etiquette, avoiding crowds, following local guidance.

If you can work from home, if you are in a profession where you can work from home and you are supported by your company to work from home continue to do that.

We also need to ensure that communities are able to adhere to the local measures that are being recommended. It's very easy to say to do something but if communities aren't enabled to do that then it becomes obviously very, very difficult for them.

So it's really important that that decline in incidence continues to decline and we don't let loose in terms of our individual-level measures and our community-level measures.

With regard to the virus variants there are a number of virus variants that WHO and the world are monitoring, these variants of concern. I don't have the specifics on the variants of concern
circulating in Mexico but globally there are a number of variants that we are tracking.

Each of these variants of concern - the B117, first identified in the United Kingdom, the B1351, first identified in South Africa, and the P1 variant that was first identified in Japan but is circulating in Brazil - each of these virus variants have been found to have increased transmissibility, which means that it has a mutation that allows the virus to bind to the cell more readily and it can infect more people.

If you have more cases then you will have more hospitalisation and that will put a burden on the healthcare system which could in turn result in more deaths. So it is important that everything that we do, virus variants circulating or not, we stay the course and we make sure that we adhere to the individual-level measures.

01:05:59

These public health and social measures, the infection prevention and control in health facilities as well as outside of health facilities work against all the viruses that are circulating, whether they are virus variants or not.

It's important that everybody out there know that because you have some control over what you do and you can take measures to keep yourself safe and keep your loved ones safe.

MR If I could just add, the trend in Mexico has been gradually downwards and it's been consistently downwards both in terms of death and cases but we're still seeing around 10,000 cases per day so it's still remarkably high.

The good thing; I think the health system in Mexico's coped. I think nearly 72% of general COVID beds are available and about the same percentage, slightly less of beds with ventilators; about 70% of ventilation or high-support beds are still available.

01:07:00

Also Mexico has administered, I think, about 2.5, 2.6 million doses of vaccine so far so Mexico has commenced the vaccine journey. One of the downsides is that the surveillance system still remains thoroughly underactive with 31% of all tests being positive, which gives you a sign at that positivity rate that there's probably still under-detecting of cases despite the relatively high numbers.
But it's good to see the deaths falling as well as the cases; it's good to see that the hospitals are coping but it's been a very, very long journey for Mexico, it's been very, very tough, as it has been for many Central and South American countries.

We're here at the presser every week and we get many questions about Brazil but it's been tough in Peru, it's been tough in Argentina, it's been tough in Colombia, it's been tough in many Central American countries including Mexico. Latin America has really taken a blow over the last 14, 16 months.

So again, the systems have coped but there are many, many, many lessons to learn around pandemic preparedness and readiness for us all globally, as the DG has said but also we need to learn the regional and subregional lessons; what are the things that made our systems cope, what are the things that made our systems not cope so well?

01:08:26

As we say many times, Mexico's not out of the woods by any means. It's coming down slowly from a very high high and what we do in the coming weeks and months will be very important in terms of exiting the acute phase of this pandemic.

Certainly getting vaccination levels up to the highest possible levels will allow the death and hospitalisations to continue to fall but there are no guarantees on transmission unless we continue to maintain the behaviours that we all know to stop this disease.

CL Thank you both. Now we come to the last question and we'll go to Donato Mancini from FT. Donato, please unmute yourself.

DO Hi. Can you hear me?

CL Yes. Please go ahead.

DO Thanks for taking my question. It's mainly for Dr Tureci and Dr Gilbert and whoever else wants to respond. You've both said access to vaccines is fundamental but we know that a big problem worldwide and one of the main barriers is actually intellectual property.

01:09:31

So what do you think would entice stakeholders to act concretely in that sense? I know that both Oxford Astra and Pfizer BioNTech have taken significant steps to increase access worldwide. But would you for example consider joining initiatives such as the WHO's CTAC? Thank you so much.
CL    Thank you very much, Donato. Let me give this first to Professor Gilbert.

SG    Thank you. I have to confess I'm not familiar with that initiative; I'm sorry. Within Oxford we always said that we wanted to have a vaccine for the world and we wanted it to be manufactured and distributed widely and we're very pleased to see that that is being done with many sublicences to different manufacturers in different parts of the world and increasing the number of doses that we initiated development of now being made available across the world.

I don't think that just making IP freely available goes anywhere close to solving this problem because it's not just the rights to use the technology that are needed.

01:10:36

It's the seed stock, the cell banks, the protocols, the assays, the standards, the reagents to do everything. This requires a great deal of support from the first company that licensed the vaccine and this can be done but it can't be done in a completely unlimited way.

So we have to recognise that it's important we have many vaccines to use across the world; those that are licensed now, those that are still in clinical trials and will be approaching licensure. We want to see a good range of vaccines ideally using different technologies because that will increase the chance of having the largest number of doses available.

Then what we need is that once those vaccines are manufactured, licensed and distributed the ones that are sitting in vaccine centres actually get used to protect people and we don't let them sit there going past their expiry date.

01:11:28

CL    Thank you very much, Professor Gilbert. Dr Tureci, please.

OT    Yes. I can only echo what Sarah has pointed out so eloquently. It is a comprehensive solution and approach we need, in particular also if it is about novel platforms and novel technologies for which even the set-up of production facilities needs to be expanded and you cannot just repurpose existing facilities.

So patents are one thing but there are so many other things we have to ensure.
Thank you both very much. With this we come to the end of our briefing. Before I hand back to Dr Tedros for the final remarks let me specifically thank our very special guests, Dr Roopa Dhatt, Dr Tureci and Professor Gilbert and of course everybody here in the room and who was online.

Also please again note the audio files and the DG's remarks will be sent shortly after this briefing and the full transcript should be found on the WHO website tomorrow. Any other follow-ups; please contact mediaenquiries@who.int

Dr Tedros.

01:12:51

Thank you. Thank you very much, Christian. I would like to again thank our guests today; to Roopa for your leadership and also to Professor Gilbert and Dr Tureci for your incredible contribution to humanity.

I'd like to assure you and would like to let you know that the WHO family is proud of you and I hope the whole world is also proud of you because you have brought the solution to address this pandemic.

So thank you so much indeed and I would like to thank all our media family also, those who have joined today. Thank you so much and also I'd like to wish all of us a happy International Women's Day. Thank you again.

One last bit, maybe final final, our translators have been with us for more than a year now, working very hard in several languages and helping the world to understand about this pandemic so we'd like to recognise their contribution and dedication. Without them we wouldn't have been here for more than a year now talking to the world through you so thank you so much to our interpreters.

Thank you again and see you in our next presser. Thank you.

TR Thank you.

01:14:44